DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 07/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CENTER FOR REHABILITATION AND HEALING LLC	932 BADDOUR PARKWAY LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/30/2018. During this Life Safety Survey, Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: ** A follow up visit conducted on 6/5/2018, revealed Quality Center for Rehabilitation and Healing was found in compliance with requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CENTER FOR REHABILITATION AND HEALING LLC	**932 BADDOUR PARKWAY** **LEBANON, TN 37087**

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{K 000}	Continued From page 1	{K 000}		

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QUALITY CENTER FOR REHABILITATION AND HEALING LLC	**932 BADDOUR PARKWAY** **LEBANON, TN 37087**

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{K 000}	Continued From page 2 A Life Safety revisit survey was conducted on 07/02/2018 for all previous deficiencies cited on 06/05/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

45th day 6-7-18 / 70th day 7-12-18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#1	445154	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CENTER FOR REHABILITATION AND HEALING LLC	932 BADDOUR PARKWAY LEBANON, TN 37087

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{K 000}	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/30/2018. During this Life Safety Survey, Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: ** A follow up visit conducted on 6/5/2018, revealed Quality Center for Rehabilitation and Healing was found in compliance with requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne Batilie
TITLE: Administrator
(X6) DATE: 6/11/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received 6-13-18

PRINTED: 05/03/2018
FORM APPROVED
OMB NO. 0938-0391

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	445154	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CENTER FOR REHABILITATION AND HEALING LLC	932 BADDOUR PARKWAY LEBANON, TN 37087

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/30/2018. During this Life Safety Survey, Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the aisle, corridor or ramp width. The findings included: 1. Observation on 04/30/2018 at 9:41 AM, revealed a trash cart stored in the means of egress on the side walk outside of the exit by room 133. NFPA 101, 19.2.3.4* (2012 Edition)	K 232	K232 - Aisle, Corridor, or Ramp Width 1. **Corrective Action**: The trash cart, bicycle and shop-vac were removed from the path of egress. The linen carts were moved in the corridors. The ADM and/or Nurse Educator Inserviced the staff to ensure egress paths are clear, required width of the corridors are maintained and linen carts are moved in the corridor so as to maintain the required width of the corridor. 2. **Identifying other residents with potential to be affected:** The facility determined all residents have the potential to be affected. 3. **Measures or Systemic Changes**: The Maintenance Director or designee will audit the corridors and egress points to ensure the required width is maintained daily for 4 weeks and then weekly for 2 months. 4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne Gutilee | TITLE: Administrator | (X6) DATE: 5/23/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 232	Continued From page 1 2. Observations on 04/30/2018 between 9:43 AM and 10:48 AM, revealed the linen carts stored in the corridors in the following locations: a. By room 130 b. By room 140 c. By room 121 d. By room 105 e. By room 114 f. By room 90 NFPA 101, 19.2.3.4* (2012 Edition) 3. Observation on 04/30/2018 at 10:17 AM, revealed storage of a bicycle and shop-vac in the means of egress outside of the exit by room 109. NFPA 101, 19.2.3.4* (2012 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 232	K234 - Cooking Facilities 1. **Corrective Action:** The deep fat fryer was centered under the hood suppression nozzle. The ADM and/or Nurse Educator inserviced the kitchen staff to ensure the cooking equipment was kept under the hood suppression system and centered underneath appropriately. 2. **Identifying other residents with potential to be affected:** The facility determined all residents have the potential to be affected. 3. **Measures or Systemic Changes:** The Maintenance Director or designee will audit the cooking equipment daily for 4 weeks and then weekly for 2 months to ensure cooking equipment is kept centered under the hood suppression system. 4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with	K 324		

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K 232	Continued From page 1 2. Observations on 04/30/2018 between 9:43 AM and 10:48 AM, revealed the linen carts stored in the corridors in the following locations: a. By room 130 b. By room 140 c. By room 121 d. By room 105 e. By room 114 f. By room 90 NFPA 101, 19.2.3.4* (2012 Edition) 3. Observation on 04/30/2018 at 10:17 AM, revealed storage of a bicycle and shop-vac in the means of egress outside of the exit by room 109. NFPA 101, 19.2.3.4* (2012 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 232	K234 - Cooking Facilities 1. **Corrective Action:** The deep fat fryer was centered under the hood suppression nozzle. The ADM and/or Nurse Educator inserviced the kitchen staff to ensure the cooking equipment was kept under the hood suppression system and centered underneath appropriately. 2. **Identifying other residents with potential to be affected:** The facility determined all residents have the potential to be affected. 3. **Measures or Systemic Changes:** The Maintenance Director or designee will audit the cooking equipment daily for 4 weeks and then weekly for 2 months to ensure cooking equipment is kept centered under the hood suppression system. 4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with	K 324		

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K 324	Continued From page 2 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to protect the cooking facilities. The findings included: Observation on 04/30/2018 at 10:11 AM, revealed the deep fat fryer was not centered under the hood suppression system. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 96, 12.1.2.2 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 324	K345 - Fire Alarm System - Testing and Maintenance 1. **Corrective Action:** The pull station next to the exit by room 109 was repaired. All pull stations were tested by outside contractor. The ADM and/or Nurse Educator inserviced the staff to ensure that pull stations work properly and report to the ADM immediately if any pull station does not operate properly. 2. **Identifying other residents with potential to be affected:** The facility determined all residents have the potential to be affected. 3. **Measures or Systemic Changes:** The Maintenance Director or designee will test random pull stations monthly during fire drills to ensure the pull stations work properly. 4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews monthly for 3 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		

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K 345	Continued From page 3 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to maintain the fire alarm system. The findings included: Observation and testing on 04/30/2018 at 11:38 AM, revealed the fire alarm pull station next to the exit by room 109 did not function properly. NFPA 101, 19.3.4.5.1 (2012 Edition) NFPA 101, 9.6.1.3 (2012 Edition) NFPA 72, 14.2.1.2.2 (2010 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353	K353 - Sprinkler System - Maintenance Testing 1. **Corrective Action:** The sprinkler heads by the mirror in the dining room, rooms 32, 35, 36 and 82 were replaced. Sprinkler heads were audited to ensure no other heads needed replacement. Outside contractors were educated on the required condition of the sprinkler heads and to identify any out of compliance during their required inspections. ADM and/or Nurse Educator inserviced staff on proper condition of sprinkler heads. 2. **Identifying other residents with potential to be affected:** The facility determined all residents in the areas of the sprinkler heads identified as non-compliant have the potential to be affected. 3. **Measures or Systemic Changes:** The Maintenance Director or designee will audit sprinkler heads in random areas daily for 4 weeks and then weekly for 2 months. ADM educated outside contractors on the required condition of sprinkler heads and to identify any out of compliance during their required inspections.	5/23/18

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K 353	Continued From page 4 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintian the sprinkler system. The findings included: 1. Observation on 04/30/2018 at 9:49 AM, revealed rust on the sprinkler by the mirror in the dining room. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.5 (2012 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition) 2. Observation on 04/30/2018 between 9:57 AM and 10:01 AM, revealed paint on the sprinklers in rooms 32 (above the tv), room 35 and room 36.NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.5 (2012 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition) 3. Observation on 04/30/2018 at 10:20 AM, revealed rust on the sprinkler in room 82-B. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.5 (2012 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 353	4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code,	K 511		

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QUALITY CENTER FOR REHABILITATION AND HEALING LLC	932 BADDOUR PARKWAY LEBANON, TN 37087

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K 511	Continued From page 5 electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the utilities. The findings included: Observation on 04/30/2018 at 9:40 AM, revealed the grounding prong missing from the plug on the sit down hair dryer. NFPA 101, 19.5.1 (2012 Edition) NFPA 101, 9.1.2 (2012 Edition) NFPA 70, 110.12 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 511	K511 - Utilities - Gas and Electric 1. **Corrective Action:** The plug on the dryer was replaced. The ADM and/or Nurse Educator inserviced the staff to ensure that plugs have the required ground prong on it and to notify the ADM or designee immediately so repairs can be made if appropriate or removal of the equipment is warranted. 2. **Identifying other residents with potential to be affected:** The facility determined all residents utilizing the sit down dryer have the potential to be affected. 3. **Measures or Systemic Changes:** The Maintenance Director or designee will audit random equipment power cords daily for 4 weeks and then weekly for 2 months to ensure all plugs have a ground plug intact. 4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the	K 741		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CENTER FOR REHABILITATION AND HEALING LLC	932 BADDOUR PARKWAY LEBANON, TN 37087

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K 741	Continued From page 6 international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to comply with smoking regulations. The findings included: Observation on 04/30/2018 at 10:02 AM, revealed the improper disposal of cigarette butts outside of the exit by room 117 (cigarette butts littering the sidewalk around combustible benches). Observations on 04/30/2018 between 9:45 AM and 10:33 AM, revealed combustible material disposed of in the metal ashcan in the following locations: a. patio outside of the quality dining room b. outside exit by room 114 NFPA 101, 19.7.4* (2012 Edition) Maintenance staff was present when these	K 741	K741 - Smoking Regulations 1. **Corrective Action:** The metal ash cans on the patio outside the quality dining room and outside exit by room 14 were removed and replaced with a more appropriate disposal so as not to allow trash to be thrown in with cigarette butts. The cigarette butts were removed from sidewalk and near combustible benches outside of the exit by room 117. ADM and/or Nurse Educator inserviced staff on proper disposal of cigarette butts. ADM and/or Nurse Educator mailed letters to family members educating them on the proper disposal of cigarette butts. Signs were posted at exits near the disposal containers to dispose of cigarette butts appropriately. 2. **Identifying other residents with potential to be affected:** The facility determined residents near the affected areas have the potential to be affected. 3. **Measures or Systemic Changes:** The Maintenance Director or designee will audit the smoking areas and exit areas daily for 4 weeks and then weekly for 2 months. 4. **How corrective action will be monitored:** The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18

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K 741	Continued From page 7 deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2018.	K 741		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day 6-7-18 — 90th day 7-23-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING _____ B. WING _____	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 03/20/2018. During this Emergency Preparedness Survey, Quality Center for Rehabilitation and Healing was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and	E 024	E024 - Policies/Procedures-Volunteering and Staffing 1. **Corrective Action**: The facility Emergency Preparedness policy was revised with regards to the use of volunteers in an emergency or the use of other emergency staffing strategies including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. ADM and/or Nurse Educator Inserviced the staff on the revised policy. 2. **Identifying other residents with potential to be affected:** The facility determined all residents have the potential to be affected during an emergency. 3. **Measures or Systemic Changes**: The facility Emergency Preparedness policy was revised with regards to the use of volunteers in an emergency or the use of other emergency staffing strategies including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. 4. **How corrective action will be monitored:** The ADM or designee will review the revised policy with the IDT. The ADM or designee will complete a response to the QAPI committee. The QAPI committee will review the revised policy at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.	5/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne Butler — TITLE: Administrator — (X6) DATE: 5/23/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/03/2018
FORM APPROVED
OMB NO. 0938 0391

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E 024	Continued From page 1 procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for the use of volunteers in the emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview on 04/30/2018 at 12:20 PM, revealed the facility had no record of polices and procedures for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This finding was verified by the administrator during the review of the facility's emergency preparedness program.	E 024		